

# Listing of current health care plan providers

Please call the toll-free number or visit the Web site listed for plan details.

**MEDCO** (new provider in 2005-2006)  
(800) 899-2587  
[www.medco.com](http://www.medco.com)

**HMO Illinois**  
(800) 868-9520  
[www.bcbsil.com/stateofillinois](http://www.bcbsil.com/stateofillinois)

**CIGNA**  
(800) 962-0051  
[provider.healthcare.cigna.com/soi.html](http://provider.healthcare.cigna.com/soi.html)

**OSF Health Plans**  
(888) 716-9138  
[www.osfhealthplans.com](http://www.osfhealthplans.com)

**Health Alliance HMO**  
(800) 851-3379  
[www.healthalliance.org](http://www.healthalliance.org)

**PersonalCare**  
(800) 431-1211  
[www.personalcare.org](http://www.personalcare.org)

**Health Alliance Illinois**  
(800) 851-3379  
[www.healthalliance.org](http://www.healthalliance.org)

**Unicare HMO**  
(888) 234-8855  
[www.unicare.com](http://www.unicare.com)

**HealthLink Open Access Plan**  
(800) 624-2356  
[www.healthlink.com](http://www.healthlink.com)

**Out-of-state managed care**  
Managed care is available in some counties in Indiana, Iowa, Kentucky and Missouri. See page 14 and 15 for more details.

## For specific information on coverage benefits:

Illinois Department of Central Management Services  
(217) 782-2548  
(800) 442-1300 toll free  
(800) 526-0844 TDD  
[www.benefitschoice.il.gov](http://www.benefitschoice.il.gov)

## For information on enrollment:

Teachers' Retirement System  
(800) 877-7896

Attn: Insurance Department  
Teachers' Retirement System  
2815 West Washington  
P.O. Box 19253  
Springfield, IL 62794-9253



## ***Table of Contents***

<i>Answers to your questions</i>	<i>page 1</i>
<i>Questions about the medical indemnity plan</i>	<i>page 4</i>
<i>TCHP prescription drug plan</i>	<i>page 6</i>
<i>Questions about the managed care plans</i>	<i>page 8</i>
<i>Monthly premiums</i>	<i>page 10</i>
<i>Coverage comparison table</i>	<i>page 12</i>
<i>TRIP managed care plans availability by Illinois county</i>	<i>page 13</i>
<i>Managed care plans availability outside of Illinois</i>	<i>pages 14 - 15</i>

# Answers to your questions



## **What is TRIP?**

The Teachers' Retirement Insurance Program (TRIP) is a comprehensive program of quality health care coverage for retired teachers and their eligible dependents.

## **Who administers TRIP?**

The Illinois Department of Central Management Services (CMS) administers TRIP. In this capacity, CMS determines coverage benefits, establishes premiums, negotiates contracts with the insurance carriers, and resolves coverage and claim problems. The Teachers' Retirement System's (TRS) role is to provide members with basic coverage information, enroll them in the program, and collect the appropriate premiums.

## **What kind of coverage is available under TRIP?**

The program offers two types of plans: medical indemnity and managed care. The Teachers' Choice Health Plan (TCHP) is a medical indemnity plan. You may enroll in TCHP regardless of where you live.

You may also enroll in one of several managed care plans. TRIP offers two types of managed care plans: health maintenance organizations (HMOs) and an open access plan. Managed care plans are located throughout Illinois and in some neighboring states. Your place of residence determines which managed care plans are available to you.

## **Who can join?**

In order to join TRIP, you must be receiving a monthly benefit from TRS under the Illinois Pension Code, Article 16, and:

- have at least eight years of creditable service with TRS *or*
- be the survivor of an annuitant or a benefit recipient who had at least eight years of creditable service.

If you are a disability recipient, you are eligible for enrollment in TRIP regardless of the years of service.

If you enroll in TRIP, you may also enroll the following dependents:

- your spouse,
- your unmarried children under age 19 (including stepchildren),
- your unmarried children under age 23 who are enrolled full-time in school, financially dependent on you for at least one-half of their support, and eligible to be claimed on your state income tax return,
- your disabled children of any age as long as they have been continuously disabled from causes originating prior to age 19, and they are financially dependent on you for at least one-half of their support and eligible to be claimed on your state income tax return, and
- your parents if they are financially dependent on you for at least one-half of their support and eligible to be claimed on your state income tax return.

## When can I join?

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If you are eligible, you can enroll yourself and qualifying dependents during the following periods:

- **When you apply for monthly pension benefits.** If you want to enroll at this point, you must return the enrollment form to TRS no later than 30 days after the effective date of the pension benefits. The insurance becomes effective the first day of the first full month of benefits or the first day of the month in which your enrollment application is received, whichever is later. You may delay your effective date of coverage up to four months after the effective date of your pension benefits. However, TRS must receive your enrollment form within 30 days of the effective date of your pension benefits.
- **When you turn 65.** TRS will mail your enrollment information within 60 days before your 65th birthday. You have six months from the date you become eligible for Medicare to enroll. If you are not eligible for Medicare, you may enroll within 30 days of your 65th birthday. The insurance becomes effective the first day of the month in which you turn 65 or the first day of the month in which TRS receives the enrollment form, whichever is later.
- **When coverage is terminated by a former plan.** You may continue coverage with another plan rather than enroll in TRIP. If this occurs, you and your eligible dependents may enroll in TRIP when coverage under the other plan is terminated. The termination must be initiated by the plan. You must return the enrollment form, along with a letter from the plan stating the effective date of termination, no later than 30 days after the effective date of termination of the plan's coverage. The insurance becomes effective the first day of the month following cancellation of coverage with the other plan.

- **During the Benefit Choice Period, if you have never been enrolled in TRIP.** You may enroll in TRIP during the Benefit Choice Period (usually May 1 through May 31 each year). The insurance becomes effective on July 1. If you or your dependent were previously covered under TRIP and terminated coverage, you may re-enroll only when you or your dependent turns age 65 or when coverage is terminated by a former plan.

## When can I enroll dependents?

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You may enroll dependents when you enroll in the program, the dependent turns 65, a change in family status occurs, or coverage is terminated by a former plan. You may also enroll dependents during the annual Benefit Choice Period if they previously have not been enrolled in TRIP.

Your dependent has six months from the date he or she becomes eligible for Medicare to enroll. If your dependent is not eligible for Medicare, he or she may enroll within 30 days of his or her 65th birthday.

You may also enroll a new dependent due to marriage, adoption, or birth. Your dependent has 31 days following the change in family status to enroll. If you are already enrolled in TRIP and your dependent's coverage is terminated by another plan, you may enroll your dependent within 30 days of the coverage's termination.

## Are benefits coordinated with other coverage?

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Yes. Benefits are coordinated with other insurance carriers and Medicare.

## Is there a pre-existing condition clause?

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No. Coverage begins immediately upon the effective date of enrollment.

## **What is precertification? Does it apply to all plans?**

Precertification is a notification process; it is not a guarantee of benefits. Precertification is **your** responsibility, and there are penalties for noncompliance.

For precertification requirements, contact the specific plan you are interested in joining.

## **When can I change plans?**

You may change plans each year during the annual Benefits Choice period. You will receive information before each Benefits Choice period. The selection you make will be in effect until the next Benefits Choice period, unless you are enrolled in a managed care plan and your primary care physician leaves that plan. In addition, a change in your permanent residence may change your managed care availability. Contact TRS immediately if either of these situations occur.

## **Is dental, vision, and life insurance coverage available under TRIP?**

No. Only health coverage is available under TRIP.

## **How much of the premium will be subsidized?**

The subsidy amount of the premium will be based on the type of coverage you select.

You will receive a **75 percent** subsidy (based on your permanent residence):

- if a managed care plan is available to you and you enroll in it.
- if no managed care plan is available to you and you enroll in TCHP.
- if a managed care plan is only partially available in your county of residence and you enroll in it or TCHP (see table beginning on page 13).

You will receive a **50 percent** subsidy (based on your permanent residence) if a managed care plan is available to you and you choose to enroll in TCHP.

## **What is Medicare Part D?**

Medicare Part D is a federal prescription drug plan benefit that will be available January 1, 2006. Eligible individuals will be contacted by their plan administrator prior to the Medicare Part D open enrollment period (November 2005). If you have questions about this program, contact your health plan administrator or your local Social Security Administration office. **Do not call TRS.**

# Questions about the medical indemnity plan



## **What is TCHP?**

The Teachers' Choice Health Plan (TCHP) is a traditional medical indemnity plan that offers a comprehensive range of benefits. Under TCHP you may:

- choose any physician for primary care or speciality needs,
- choose any hospital for general medical services,
- change physicians or hospitals as you desire, and
- enhance your benefits by using network providers.

TCHP provides benefits for both medical (including mental health and substance abuse) and prescription drugs. The plan covers charges for services and supplies that are determined to be medically necessary by the plan administrator and are based on usual and customary (U&C) charges for out-of-network providers or negotiated fees for network (PPO) providers.

TCHP is subject to annual plan deductibles, coinsurance and maximum life time benefits. Refer to page 12 for a summary of the TCHP benefits. For detailed coverage information, contact the plan administrator.

## **What are usual and customary (U&C) charges?**

U&C is an amount determined by the medical plan administrator to be within a specified percentile of charges made by providers for similar services by geographic area. If a charge exceeds usual and customary, you are responsible for the portion of the expense that is above U&C. Amounts in excess of U&C are not applicable to your annual plan deductible or your out-of-pocket maximum.

## **What are PPOs and how many are in the TCHP network?**

Preferred provider organizations (PPOs) under the TCHP are doctors and hospitals, throughout Illinois and surrounding states, that provide quality inpatient and outpatient care at reduced rates, resulting in savings to you.

There are more than 225 PPO hospitals in the TCHP network.

## **What is the CIGNA Hospital Network?**

It is a nationwide network of hospitals that have agreed to participate under the TCHP. An enhanced 80 percent benefit is available by using a participating hospital or facility.

You may access the participating provider list on the CIGNA Web site at:

<http://provider.healthcare.cigna.com/soi.html>.

Or, you may call CIGNA at (800) 962-0051 to find out which providers are participating.

## **What is the CIGNA HealthCare PPO Physicians Network and who can access it?**

The PPO Physicians Network is a nationwide network of physicians that have agreed to participate at negotiated rates under the TCHP.

All TCHP **non-Medicare participants** may use services from a participating provider and receive an enhanced benefit.

## **What are the advantages of using the CIGNA HealthCare PPO Physicians Network?**

The benefits for covered services are paid at 80 percent of a negotiated fee and U&C limits will not be applied.

You may access the participating provider list on the CIGNA Web site at:

<http://provider.healthcare.cigna.com/soi.html>. Or, you may call CIGNA at (800) 962-0051 to find out which providers are participating.

### **What if I do not use a CIGNA HealthCare PPO Physicians Network provider?**

Standard plan benefits of 60 percent of U&C charges for eligible covered professional services apply for all providers who are not participating in the network.

### **Does TCHP have a pharmacy benefit and a network of pharmacies available?**

Yes. TCHP has a pharmacy benefit. The TCHP pharmacy network consists of participating pharmacies located throughout the U.S., including independent community pharmacies and major pharmacy chains.



You can receive a maximum 60-day prescription drug supply when using the network pharmacy. However, copayments are doubled for any prescription exceeding a 30-day supply.

A mail order pharmacy program is also available for a 90-day supply of “maintenance” or long-term medication for direct home delivery for a mail order copayment.

### **What happens if I move or live in another state and there are no managed care plans available?**

You should notify TRS of any change in address. If you live in an area without access to a managed care plan you will be enrolled in TCHP. You will receive a 75 percent subsidy.

# TCHP prescription drug plan



MEDCO Health Solutions is the prescription drug plan administrator. The coverage provides both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription.

## **Annual out-of-pocket maximum**

For in-network benefits and the Mail Service Program, an annual out-of-pocket maximum of \$1,250 (last year \$1,050) applies. Out-of-network claims do not count towards the annual out-of-pocket maximum.

## **In-network benefits**

When using the prescription drug identification card:

- No plan year deductibles; no claim forms to file.
- 20 percent coinsurance with minimum and maximum copayments (1 to 30-day supply):

<b>Type of Prescription</b>	<b>Minimum</b>	<b>Maximum</b>
Generic	\$7	\$ 50
Formulary Brand	\$14	\$100
Non-Formulary Brand	\$28	\$150

- The maximum days supply available at one fill is 60 days. The copayment/coinsurance amount will double.
- When the pharmacy dispenses a brand drug for any reason, and a generic is available, you must pay the cost difference between the brand product and the generic product, plus the appropriate generic copayment/coinsurance amount.
- If only a brand drug is available, the appropriate brand copayment/coinsurance will apply.

- When the price of a prescription is lower than the copayment, the pharmacist will collect the lower amount.

When medication is purchased at an in-network pharmacy without presentation of the prescription drug identification card, you will be charged the full retail cost of the medication. The claim will be processed as if the prescription was filled at an out-of-network pharmacy.

## **Out-of-network benefits**

Prescription drugs may be purchased at out-of-network pharmacies. Reimbursement will be at the applicable brand or generic in-network price minus the appropriate in-network copayment/coinsurance amount. In most cases, the cost of the prescription drugs will be higher when not using in-network pharmacies. Prescriptions filled by an out-of-network pharmacy will require the completion of a claim form (available from MEDCO) and supporting documentation.

## **Mail Service Program**

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Maintenance medications are available through mail order:

- 20 percent coinsurance with minimum and maximum copayments (90-day supply):

<b>Type of Prescription</b>	<b>Minimum</b>	<b>Maximum</b>
Generic	\$14	\$100
Formulary Brand	\$28	\$200
Non-Formulary Brand	\$56	\$300

## **Coordination of benefits**

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This plan coordinates with Medicare and other group plans; the appropriate copayment/coinsurance will be applied for each prescription filled.

## **Exclusions**

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The plan reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

# Questions about the managed care plans



## What are managed care plans?

Managed care plans, including HMOs and OAPs, are prepaid health plans that provide medical benefits, including prescription drugs. You may choose from seven managed care plans. The distinct advantages in selecting managed care health plans are lower out-of-pocket costs and virtually no paperwork. Like any health plan option, managed care has its limitations including geographic availability and provider networks. If you are considering managed care, we urge you to explore and research the various plans available to you.

## If I enroll in an HMO, do I have to go to the same doctor for all my medical needs?

You must choose a doctor from those participating in the HMO provider network. This doctor becomes your primary care physician (PCP).

All routine medical care, hospitalizations, and referrals for specialized medical care must be coordinated under the direction of your primary care physician.

When care is coordinated through the PCP, you only pay a predetermined copayment. No annual plan deductibles are required for these plans.

## Do all HMOs provide the same level of coverage?

All HMOs must provide a standard level of benefits; however, different limitations apply to which services are covered and to what extent those services are covered. The standard benefits are listed in the Coverage Comparison table on page 12. Each HMO can provide specific details about levels of coverage under its plan. You are responsible for contacting the HMO for information.

## What are the copayments for prescriptions?

Generic	\$7
Formulary Brand	\$14
Non-Formulary Brand	\$28

You may contact the HMO's prescription benefit manager for more detailed information including a listing of the preferred/formulary drugs.

## What is the maximum day prescription drug supply at one fill?

You usually can receive a 30-day supply. However, some plans allow for a 60-day supply of maintenance medication. You may contact the HMO for information.

## What is the HealthLink Open Access Plan (OAP)?

OAP is a unique managed care plan because it has three levels of benefits. The program offers two managed care networks, a Tier I network and a Tier II network. Out-of-network benefits are also available, so you can have great flexibility in selecting care providers. The important thing to remember is the level of benefits is determined by the selection of care providers.

## What is the level of coverage for OAP?

The benefit level for hospitals, physicians, and other services will be highest if you select a Tier I provider, which is often a 100 percent

benefit after a copayment. The Tier II network is generally a 90 percent benefit. The out-of-network is generally 80 percent of usual and customary charges.

It is important to know you may mix and match providers. For example, you may utilize a Tier II physician and receive care in a Tier I hospital. In this example, your physician's claim would be payable under Tier II at 90 percent benefit and the hospital would be paid at the Tier I 100 percent benefit.

### **Who should I contact to get the provider directory?**

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Contact HealthLink directly to get a listing of the provider and benefit levels. In considering the OAP, compare all benefits to other options. There are important similarities and differences in benefits for prescription drug coverages and mental/health substance abuse services, as well as hospital, physician, and other services.

### **Is OAP considered a managed care plan for subsidy purposes?**

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Yes, if you select OAP, you will receive the managed care subsidy.

# Monthly premiums

## through June 30, 2006

Type of Plan	Not Medicare Primary Under age 23	Not Medicare Primary Age 23-64	Not Medicare Primary Age 65 & above	Medicare Primary All ages
<b>Benefit recipient</b> enrolled in any managed care plan	\$49.49	\$153.68	\$209.92	\$60.11
<b>Benefit recipient</b> enrolled in TCHP when a managed care plan is available in their county of residence	\$122.42	\$362.13	\$557.96	\$157.55
<b>Benefit recipient</b> enrolled in TCHP when a managed care plan is not available in their county of residence	\$61.21	\$181.07	\$278.98	\$78.77
<b>Dependent beneficiary</b> enrolled in any managed care plan	\$197.97	\$614.71	\$839.69	\$212.21
<b>Dependent beneficiary</b> enrolled in TCHP when a managed care plan is available in their county of residence	\$244.84	\$724.26	\$1,115.91	\$315.10
<b>Dependent beneficiary</b> enrolled in TCHP when a managed care plan is not available in their county of residence	\$244.84	\$724.26	\$1,115.91	\$236.33

Your monthly premium is based upon the type of coverage you select and your permanent residence on file with TRS. This is why it is extremely important that you notify TRS of any eligibility and/or address changes as soon as possible. **Corrections to eligibility that result in a premium change will only be processed up to six months retroactively. There are no exceptions to this policy.**

It is your responsibility to ensure premium changes are reflected correctly in your monthly benefit.

### **Do dependent beneficiaries receive a premium subsidy?**

Medicare primary dependent beneficiaries, enrolled in a managed care plan or in the TCHP when no managed care plan is available, receive a premium subsidy. See premium table above.

### **What if I want to terminate either my or my enrolled dependents' coverage under TRIP?**

Notify TRS in writing of your decision to terminate coverage. Cancellation will be effective the first of the month following receipt of the request. You can only re-enroll yourself or your dependent upon turning 65 or if your coverage is terminated by your existing plan.

### **What should I, or my dependent, do when we turn 65 or become eligible for Medicare due to a medical condition (Medicare Disability or Medicare ESRD)?**

You must enroll in both Medicare Parts A and B to qualify for the lower premiums. Send a copy of your Medicare card to TRS. If you or your dependent are actively working and eligible for Medicare or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare COB Unit.

If you do not qualify at age 65 for Medicare benefits, documentation from the Social Security Administration must be sent to TRS.

**What is the premium if I enroll in a county with partial managed care available?**

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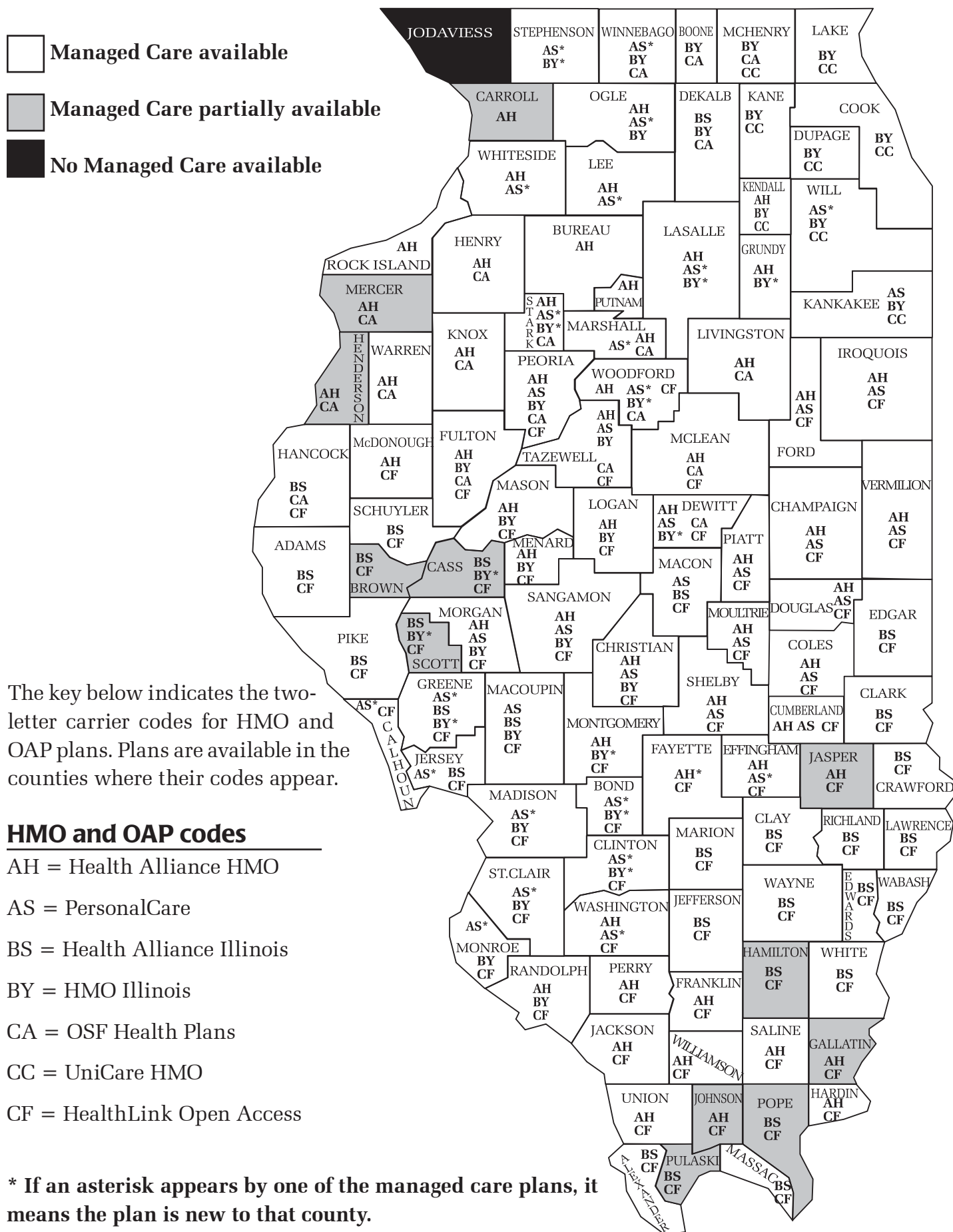
In counties with partial managed care availability, a benefit recipient may enroll in the medical indemnity plan without receiving a reduced premium subsidy. The monthly premiums are the same as those listed for TCHP when a managed care plan is not available.

# Coverage comparison table

Benefit	Medical Indemnity Plan TCHP	Managed Care Plans HMO	Open Access Plan (OAP) Tier I	Open Access Plan (OAP) Tier II	Open Access Plan (OAP) Tier III (Out-of-Network)
Plan year maximum benefit	\$2,000,000	Unlimited	Unlimited	Unlimited	\$1,000,000
Lifetime maximum benefit	\$2,000,000	Unlimited	Unlimited	Unlimited	\$1,000,000
Patient Responsibilities					
Annual out-of-pocket maximum Per enrollee	General: \$1,000 (last year \$800) Non-PPO: \$4,000	\$1,500	Not applicable	\$600	\$1,500
Other deductibles/copayments: Emergency room Non-PPO/Out-of-network hospital admission	\$250 \$250	\$100 No coverage	\$100 See Tier III for benefit level	\$100 + 10% network charges See Tier III for benefit level	\$100 + 20% of U&C \$300 + 20% of U&C
Annual plan deductible Must be satisfied for all services	\$250 TCHP primary participant (non-Medicare) \$250 Medicare primary participant	\$0	\$0	\$200 per enrollee	\$300 per enrollee
Plan Benefit Levels Comparison*					
Inpatient	80% PPO 70% or 60% non-PPO	\$150 copayment	\$150 copayment	90% of network charges after \$200 copayment	80% of U&C after \$300 copayment
Outpatient surgery	80% for PPO network provider	100%	100%	90% of network charges	80% of U&C
Diagnostic lab & X-ray	80% of U&C	100%	100%	90% of network charges	80% of U&C
Durable medical equipment	80% of U&C	80% of network charges	100% of network charges	90% of network charges	80% of U&C
Physician office visit	80% PPO 60% of U&C non- PPO	\$10 copayment	\$10 copayment	90% of network charges	80% of U&C
Preventive services	80% or 100% for specific services	\$10 copayment	\$10 copayment	90% of network charges	Covered in-network only
Prescription Copayments (Refer to page 6 for TCHP coinsurance percentages and maximum amounts.)					
\$7 Copay (30-day supply) \$14 Formulary brand copay \$28 Non-formulary brand copay					

\*Note: Benefit levels and examples are general guidelines for comparison purposes only. Contact the plan administrator for specific benefit levels and coverage details.

## TRIP managed care plans availability by Illinois county



# Managed care plans availability outside of Illinois

The following states and counties have a managed care plan available.

<i>State</i>	<i>County</i>	<i>Managed Care Code</i>	<i>Partial</i>	<i>State</i>	<i>County</i>	<i>Managed Care Code</i>	<i>Partial</i>
<b>Indiana</b>	Clay	CF	X	<b>Kentucky</b> <i>(continuation)</i>	Lyon	CF	X
	Daviess	BS	X		Marshall	CF	X
	Dubois	BS, CF	X		McCracken	CF	
	Gibson	BS, CF			Trigg	CF	X
	Greene	CF	X		Union	CF	X
	Knox	BS, CF			Webster	CF	X
	Lake	BY, CC		<b>Missouri</b>	Adair	CF	X
	Martin	BS	X		Audrain	CF	X
	Parke	CF	X		Barry	CF	X
	Pike	BS	X		Barton	CF	X
	Porter	BY, CC	X		Bollinger	CF	X
	Posey	BS, CF	X		Boone	CF	X
	Spencer	BS, CF	X		Butler	CF	X
	Sullivan	CF			Callaway	CF	X
	Vanderburgh	BS, CF	X		Camden	CF	X
	Vermillion	CF			Cape Girardeau	CF	X
	Vigo	CF			Carter	CF	X
	Warrick	BS, CF	X		Cedar	CF	X
<b>Iowa</b>	Lee	BS			Chariton	CF	X
	Scott	AH			Christian	CF	X
<b>Kentucky</b>	Caldwell	CF	X		Clark	BS, CF	
	Calloway	CF	X		Cole	CF	X
	Carlisle	CF	X		Cooper	CF	X
	Crittenden	CF			Crawford	CF	X
	Fulton	CF	X		Dade	CF	X
	Graves	CF	X		Dallas	CF	X
	Henderson	CF	X		Dent	CF	X
	Hickman	CF	X		Douglas	CF	X
	Hopkins	CF	X		Dunklin	CF	X
	Livingston	CF			Franklin	CF	X
				<i>continued on next page</i>			

\* Indicates counties with plan changes.

# Managed care plans availability outside of Illinois

The following states and counties have a managed care plan available.

State	County	Managed Care Code	Partial	State	County	Managed Care Code	Partial
Missouri (continuation)	Gasconade	CF	X	Missouri	Pemiscot	CF	X
	Greene	CF	X		Perry	CF	
	Hickory	CF	X		Phelps	CF	X
	Howard	CF	X		Pike	CF	
	Howell	CF	X		Polk	CF	X
	Iron	CF	X		Pulaski	CF	X
	Jasper	CF	X		Putnam	CF	X
	Jefferson	CF	X		Ralls	CF	
	Knox	CF	X		Randolph	CF	X
	Laclede	CF	X		Reynolds	CF	X
	Lawrence	CF	X		Ripley	CF	X
	Lewis	BS	X		Schuyler	CF	X
	Lincoln	CF	X		Scotland	CF	X
	Linn	CF	X		Scott	CF	
	Macon	CF	X		Shannon	CF	X
	Madison	CF	X		Shelby	CF	X
	Maries	CF	X		St. Charles	CF	
	Marion*	CF	X		St. Francois*	CF	X
	McDonald	CF	X		St. Louis	CF	
	Miller	CF	X		St. Louis City	CF	
	Mississippi	CF	X		Ste. Genevieve	CF	
	Moniteau	CF	X		Stoddard	CF	X
	Monroe	CF	X		Stone	CF	X
	Montgomery	CF	X		Sullivan	CF	X
	Morgan	CF	X		Taney	CF	X
	New Madrid	CF	X		Texas	CF	X
	Newton	CF	X		Warren	CF	X
	Oregon	CF	X		Washington	CF	X
	Osage	CF	X		Wayne	CF	X
	Ozark	CF	X		Webster	CF	X
					Wright	CF	X

\* Indicates counties with plan changes.